

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-024489

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No.

3030

STATE FILE NUMBER

FILED JUN 17 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 40 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Trinity Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 6821 Oak	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Louis Middle F. Last Meyer		4. DATE OF DEATH Month May Day 27, Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Mar. 15, 1883
9. AGE (last birthday) 80		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Banker	
11. BIRTHPLACE (City and state or country) Kansas		12. CITIZEN OF WHAT COUNTRY U. S. A.	

13a. FATHER'S NAME Eugene L. Meyer	13b. MOTHER'S MAIDEN NAME Emma Moore	14. NAME OF HUSBAND OR WIFE Elizabeth May Meyer
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	17. INFORMANT James Mason Meyer, 223 Witchwood Lane
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-Pneumonia DUE TO (b) Chronic Brain Syndrome DUE TO (c) Arterio-Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2-3 days 5 yrs 5 yrs
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Degeneration Spinal Cord		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from 1945 to May 27-1963 Death occurred Trinity Lutheran - 121 m on the date stated above, and to the best of my knowledge, from the causes stated.	21b. I saw him alive on May 27-1963
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22a. SIGNATURE Don Carlos Peete M.D.	22b. ADDRESS 1500 Prof. Bldg	22c. DATE SIGNED 5-28-63
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-29-63	23c. NAME OF CEMETERY OR CREMATORY Mt. Washington	23d. LOCATION City, town, or county (State) Kansas City, Missouri
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24. FUNERAL DIRECTOR Stine & McClure, Kansas City, Mo.	25. DATE RECD. BY LOCAL REG. 5-28-63	26. REGISTRAR'S SIGNATURE Ruth Long
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF
Don Carlos Peete M.D.

VS 300
Rev. 4/59
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2 3868
3
4 0
5 3
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7 1
8 1
9 4500
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12 68-0
13

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Tracy M. Cundy

Licensed Embalmer No. 5125

P. O. Address Kansas City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Dr. Dan C. Foster
1500 Hwy. Bldg.
new till 6:00pm

0-80